Introduction: Dysplastic naevi (DN) have an associated risk of malignant melanoma (MM), which increases with increasing numbers of DN and personal/family history of DN. No agreed national management standards exist.
Suggested standards:
1. Surveillance [3]1 per year with family/personal history of MM and/or personal history of $\geq$ 3 DN
2. Lesions should be excised with a 2mm margin if MM cannot be ruled out
3. All patients with DN are taught self-examination
Methods: We completed a retrospective study at four plastic surgery units in the South West. All patients $\leq$ 16 years with a histological diagnosis of DN or MM were evaluated.
Results: 42 lesions in 40 patients, mean age 11 years were analysed over a 10-year period. 86% underwent excision biopsy; 68% of these were excised with a 2mm margin. 20 patients were followed-up, mean duration 9 months. 5% of all lesions excised were found to be MM. 13% of patients discharged had documented discussion about self-examination.
Conclusions: The benefits and costs associated with out-patient surveillance in this patient cohort remain controversial. We recommend suspicious lesions are excised with a 2 mm margin. Self-examination should be advocated and documented for all patients. National standards are required to standardize management.

0869: TEN-YEAR EXPERIENCE OF MANAGING ECTROPIONS AT A SINGLE CENTRE IN SCOTLAND

Parneet Gill[2], Alex Lambah[2], Stephen Morley[1]. [1] *Canniesburn Plastic surgery Department, Glasgow, UK;* [2] *Ninewells Plastic Surgery Unit, Dundee, UK.*
Introduction: This study presents the outcomes of ectropion treatment at the Canniesburn Plastic Surgery Department Glasgow.
Method: Patients with ectropion were identified retrospectively from the theatre database between 1998-2008. Case notes were searched for clinical information looking at aetiology, ectropion classification, recurrence rates and complications as primary outcomes.
Results: Underlying aetiology consisted of fifty-six secondary to skin cancer, four cases post-burns injury, five cases due to facial palsy, five cases from benign causes, five cases from trauma and four of unknown aetiology. Documentation of ectropion classification was poor with fifty patients (63%) having no classification specified. Of the seventy-nine patients, 53% were treated with a single procedure. 37% required 2-4 operations and 10% required 5 or more operations. High re-operation rates were noted in the facial palsy (80%) and skin cancer (11%) cohort. Complications included six infections (8%) and two wound dehiscence (3%).
Conclusion: Ectropion was poorly classified and documented in patient notes. Surgical treatment was associated with a recurrence rate of 47%, with high frequency of re-operations noted in facial palsy and skin cancer groups. Accurate classification of ectropion may help in stratifying surgical management according to ectropion type and underlying aetiology.

0930: THE EFFECTS OF THE LOW PRIORITY PROCEDURE POLICY ON PRACTICE AND TRAINING

Marnie Fullarton, Debbie Hunt, Kate Williams, Saif Rhobaye, Ali Juma. *Countess Of Chester Hospital, Chester, UK.*
Aim: In 2010 the Department of Health introduced the Low Priority Procedure (LPP) policy. This targets certain cosmetic operations in Plastic surgery and sets strict criteria on whether patients are offered surgery. We investigated if this policy has reduced our case load.
Method: LPP referrals from 2005-2012 were reviewed. Referral date, demographics, PCT, operation date and where appropriate reasons for refusal of surgery were recorded.
Results: 784 referrals for LPP were received, 673 were female and 141 male. Of the 784, 313 had surgery: 72 breast reductions, 68 breast augmentations, 55 removal/exchange breast implant, 34 pinnaplasty, 33 abdominoplasty, 13 blepharoplasty, 11 gynaecomastia excisions, 7 rhinoplasty and 20 others. Operations fell from 45 in 2007 to 26 in 2012. Abdominoplasty and cosmetic breast surgery have reduced most over this time. The commonest reason for refusal was not fulfilling PCT criteria. Interestingly LPP referrals have not reduced since 2010 when the policy was introduced.
Conclusion: Since LPP our case load has reduced. How this impacts on specialist training is under review by Sir Bruce Keogh. The Welsh model of screening all LPP referrals nationally has been effective since 2004. This model could reduce the number of inappropriate referrals if introduced to England.

0934: FROM GUIDELINES TO STANDARDS OF CARE: INCREASING WORKLOAD, BUT DIMINISHING PATIENT BURDEN IN OPEN TIBIAL FRACTURES

Shakeel Rahman, Ryan Trickett, Ian Pallister. *Morriston Hospital, Swansea, UK.*
Background: Coordinated ortho-plastic surgery is the standard of care for open tibial fractures, aiming to minimise complications and unplanned revision surgery.
Aim: To establish whether the BOA/BAPRAS standards of care have altered referral pattern, workload and patients' surgical burden.
Methods: Two cohorts were reviewed, Guidelines (pre-2009) and Standards (2009-2011). Comparison was made between patients directly admitted (DAP) and transferred (TP) for the first 30 days post injury.
Results: The admission rate increased from 2.7/month (Guidelines) to 4.0/month (Standards). The percentage of TP rose from 30% to 77%. In both time periods, TP required significantly more operative procedures than DAP. With early coordinated care, the DAP group have undergone less mean operations (2.9 to 1.7). Those referred outside the terms of guidelines or standards - limb salvage (LS) - have the highest amputation rate.
Conclusions: Implementation of the standards has significantly increased the workload and the efficiency of care for open tibial fractures in our Ortho-Plastic Unit. Long-term follow up is needed to determine if efficiency equals efficacy. A small group of mainly elderly patients (LS) highlight the importance of early referral, as even seemingly 'simple' cases can prove to be catastrophic.

0946: CLINICAL AND FINANCIAL IMPLICATIONS FOLLOWING AN EARLY DISCHARGE PROTOCOL FOR REGIONAL NODE DISSECTIONS FOR SKIN CANCER – THE FRENCHAY HOSPITAL ALGORITHM

Guirgis Awad, Shaheel Chummun, Antonio Orlando. *Frenchay Hospital-North Bristol NHS Trust, Bristol, UK.*
Introduction: At Frenchay Hospital, we have developed a protocol for the discharge of patients following lymph node dissection (LND) for skin cancer within 72 hours post-operatively. This study reviews the outcome of the new discharge algorithm and any financial benefits incurred.
Methods: Data was collected on the demographics and outcome of 50 consecutive patients operated by a single surgeon for LND for skin cancer, over a 16 months period. We also reviewed the length of hospital stay and any savings made.
Results: 50 patients (31M: 19F) with a mean age of 66.1 years were recruited. 22 axillary, 15 neck and 13 groin dissections were performed. 62% of patients were operated upon within 2 weeks of being seen in clinic. The mean hospital stay was 1.9 days, compared to 9.5 days prior to the new discharge algorithm and single surgeon operator. The complication rate reduced from 50% to 24%. Financially, this resulted in 380 bed days saved over 16 months, equating to a saving of £83,600 (@£220/bed day).
Conclusion: The presented algorithm is an efficient and safe pathway from consultation to safe discharge, with the reduction in hospital stay and significant financial gains.

0964: MICROSURGICAL TRAINING – A LARGE CENTRE EXPERIENCE

Daniel Bernard Saleh, Richard Pinder, Mark I. Liddington. *Leeds General Infirmary, Leeds, UK.*
Introduction: Microvascular surgery is now a key skill, rather than subspecialty of reconstructive surgery. No studies have compared the authentic training experience with that of trainer surgeons.
Methods: A retrospective database review on consecutive free flaps performed between 1995-2010 were reviewed. Microvascular success, failure and the incidence of microvascular complication were analysed and compared. A trainee procedure was deemed both flap harvest and microvascular reconstruction.
Results: Trainees performed 11% of the total case load (188/1709). Total failure rate was 4.3% for consultants versus 7.2% ($P>0.05$). Re-exploration of vascular anastomosis was 11% versus 7% ($P>0.05$) for trainee and consultant respectively. Intra/post-operative microvascular problems

were greater for trainees, yet overall failure did not reach significance. Mean warm ischaemic time for trainer and trainee were 63 and 65 minutes respectively ($p>0.05$). The highest proportion of cases were oncological and traumatic reconstructions. No significant difference between microvascular complication/failure was observed between these subgroups.

Conclusion: Trainee failure rate in this large experience is comparable to other unit experiences for senior surgeons. Moreover with appropriate supervision success rates comparable to trainers is evident. In an era where the trainee has limited exposure, skill acquisition may have to be targeted through high volume cost effective units.

0973: SKIN CANCER DIAGNOSIS HIT OR MISS? THE LEICESTER EXPERIENCE

Kwang Chear Lee, Rajshree Jayarajan, Maharukh Daruwalla. *Leicester Royal Infirmary, Leicester, UK.*

Introduction: Accurate clinical diagnosis of skin lesions aids in the prioritisation of skin cancer treatment and avoids unnecessary excisions. Our objective was to assess the accuracy of clinical diagnosis and compare the accuracy across different specialities.

Methods: Data was collected retrospectively from histology reports obtained following a trawl of all skin pathologies at Leicester Royal Infirmary between June and December 2011. Only malignant or pre-malignant skin lesions were included. Clinical histories were compared to final pathology reports.

Results: 791 lesions were excised from 650 patients. 57.1 % of patients were male, and mean age was 72 years. Overall, clinical diagnosis was correct in 82.4% of cases. 91% of BCCs and 77% of SCCs were diagnosed correctly preoperatively but only 70% of malignant melanomas had accurate pre-operative diagnoses. Dermatologists were most likely to correctly diagnose a malignant/pre-malignant skin lesion correctly (84.7%), followed by Plastic surgeons (86.2%) with no significant difference between these 2 groups ($p=0.707$). General practitioners however had a significantly lower accuracy of 60.1% ($p<0.0001$).

Conclusions: Our overall rate of accurate clinical diagnosis is comparable to other studies however intervention is required to improve the rate of melanoma identification and the ability of general practitioners in recognising malignant skin cancers.

0995: THE USE OF BLOOD PRODUCTS IN FREE FLAP BASED BREAST RECONSTRUCTION – A COST AND SAFETY ANALYSIS

Christopher Macdonald, William Reeve, Anita Hazari. *Queen Victoria Hospital, East Grinstead, UK.*

As surgeons we are under increasing pressure to improve efficiency and cost saving without negatively impacting on the quality and safety of our patient's care. Published rates of red cell transfusion in free flap based breast reconstruction range widely (18-80%). We felt that our transfusion rates were low enough that routinely cross matching blood was likely to be a poor use of resources.

We retrospectively reviewed a year of free flap based breast reconstruction activity at a regional centre. There had been 141 free flaps performed on 130 patients. One patient received an elective pre-operative platelet transfusion and five patients received red cell transfusions (5/130, 3.8%). Two patients received blood intra-operatively whilst the rest received red cells over days 1 to 4 post-op. None of the patients had abnormal antibodies and all could have safely received universal donor (O negative) blood.

124 patients had blood needlessly cross matched at significant expense. The patients that did require transfusion could either have received universal donor blood or have safely waited for blood to be cross matched. We would encourage other departments to review their practice as a potential area for improving cost efficiency without any additional increase in risk.

1184: ATYPICAL FIBROXANTHOMA: 10 YEAR SURGICAL EXPERIENCE, DO WE NEED GUIDELINES

Amir Sadri, Debbie Hunt, Leila Touil, Ahmed El Gawad, Mohammed Maher, Ali Juma. *Countess Of Chester Hospital, Chester, UK.*

Introduction: Atypical fibroxanthoma (AFX) is a malignant derma tumour. A lack of appreciation for this tumour can lead to loss to follow-up and lack of treatment. No guidelines exist for the management of AFX. We present our 10 year experience with these malignant tumours of the skin.

Methods: A retrospective review of all cases of AFX was performed between 2002 to 2012. The following outcomes; location of lesion, method of biopsy, excision margin, total follow-up period, metastases, recurrence and time to recurrence and finally deaths were recorded.

Results: Thirty-three cases of AFX were treated between 2002-12. The scalp (67%) was the commonest site and predominated in elderly male individuals (90.9%). Biopsy was performed in 30% of cases. Three percent of biopsy proven AFX did not go on to have formal excision. Four lesions (12%) were incompletely excised. The recurrence in incompletely excised cases was 50% and 6.1% overall. 18% of patients were discussed at an MDT. No deaths were recorded.

Conclusion: This is the largest UK series of AFX. It shows similar management issues that other series have described such as lack of follow-up, incomplete excision without re-excision and lack of MDT discussion.

1244: COMMUNICATING THE LOCATION OF POTENTIAL SKIN NEOPLASMS FOR EXCISION BETWEEN THE REFERRING AND THE OPERATING DOCTOR – AN AUDIT OF SKIN LESION REFERRALS IN WHANGANUI, NEW ZEALAND

Naomi Bullen, Fraser Welsh, Semisi Aiono. *Whanganui Hospital, Whanganui, New Zealand.*

Introduction: Melanoma and non-melanoma skin cancer are widely prevalent in New Zealand. A clear referral letter is essential to correctly define the location of potential skin cancer requiring surgical treatment.

Methods: Information localising target lesions for patients seen in the local anaesthetic theatre in Whanganui Hospital New Zealand was recorded during a two month period (April-May 2012 inclusive). The surgical department and referring GPs were then educated regarding improvements to the referral process. The audit cycle was then completed (September-October 2012 inclusive).

Results: There were 100 patients in the primary study and 76 in the re-audit. The number of patients whose lesion was not identifiable from the referral letter decreased from 30% to 23.7%. The number of patients whose lesion could not be identified by either referral letter or patient themselves fell to 9.2% from 13%. There was an increase in inclusion of photographs from 3.0% to 9.3%

Conclusions: Use of photographic referral for suspicious skin lesions is under-utilised in our service. Relying on the patient or the referral text to correctly identify the lesion leaves room for error. The second audit shows small improvements but further education is needed to meet our target of pictorial localisation with each referral.

1279: RE-EXCISION OF BCCS WITH POSITIVE HISTOLOGICAL MARGINS – IS THIS NECESSARY?

Victor Ki-Shing Miu, Dua Saeed, Jasmine Tang, Paolo Matteucci. *Castle Hill Hospital, Hull, UK.*

Most BCCs are treated with excision although depending on the nature of the lesions, other treatment modalities can be used. The British Association of Dermatologists issued a guideline in 2008 for the management of BCCs. It is suggested that all BCCs with positive margins will needed to be treated by re-excision.

Methods: Retrospective case-note analysis of all BCCs excised over a one-year-period in our unit.

Results: 745 procedures were performed. 51 out of 86 incomplete BCC excisions received re-excision. 53% of all re-excision specimens had no residual BCCs. However, with high risk histological subtypes, the negative re-excision rates decrease to 47%. In the low risk histological subgroup, specimens contained no residual BCCs in 80% of the cases of re-excision. 15 high risk BCCs with positive margins were treated conservatively; of which 3 had a recurrence of their BCCs (20%). In low risk subtype all 9 patients receiving conservative treatment, have no evidence of recurrence to date.

Conclusion: Large numbers of re-excision specimens for 'positive margin' BCCs, contained no residual BCC. This is especially true in the low risk subtype BCC. However, each patient should be assessed on a case by case basis and offered re-excision or surveillance where appropriate.

1283: TETANUS IMMUNISATION: DOCUMENTATION AND MANAGEMENT

Jurga Pikturnaite, Margarita Moustaki, Jamil Ahmed, Matthew James. *Guys and St Thomas NHS Foundation Trust, London, UK.*